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TREASURE STATE HEALTH

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Hospital Construction Program Observes 20th Anniversary

August 13th marks the 20th anniversary of the Hospital Construction Program with the enactment of hospital construction Federal legislation known as the Hill-Burton Law. From July 1, 1947, to May 1, 1966, the allotment to Montana has been $11,642,-935, R. J. Munzenrider, director of the State Board of Health Division of Hospital Facilities has announced.

Since the inception of the program, 66 projects in 37 communities have been approved. The total cost of these projects has amounted to $32,919,000 with $21,776,000 provided by the local communities.

The original program under the 1946 Hill-Burton legislation was for the construction of general hospitals and public health centers. The program was later extended to include long-term care facilities (nursing homes and chronic disease facilities), diagnostic or treatment centers, and rehabilitation facilities. In 1963 amended legislation extended financial assistance to community mental health centers, facilities for the mentally retarded, and education facilities for the various health professions. The 1964 amendments added modernization grants for renovating or replacing the nation's obsolete facilities.

Montana applications for Federal financial assistance continue to exceed the available Federal funds. These funds are allocated at 40%, with the local community supplying 60%. A priority sequence for construction and modernization is established in the State Plan. Area priority and the availability of Federal funds is considered in approval of the applications.

Federal Funds Provide Impetus

Whereas the local communities have provided by far the larger sum, the program has: (1) advanced the concept of area wide health facility planning; (2) spurred the building of health facilities in areas formerly without them; (3) helped replace hazardous and obsolete plants; (4) encouraged the expansion of some facilities which were overcrowded; (5) improved the central and ancillary services of others; (6) provided for a better distribution of facilities and encouraged the establishment of construction standards.

Advisory Council

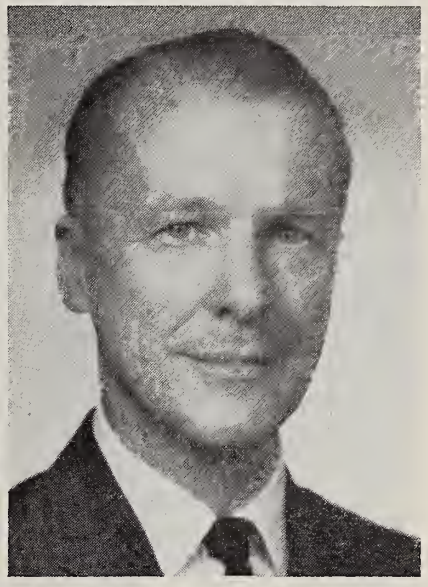
Ever since the inception of the program, the State Board of Health has had the advice and recommendations from a citizens' advisory hospital council. Following the 1963 amendments providing for matching funds for mental health centers and mental retardation facilities a new council, "The Hospital, Medical and Related Facilities Advisory Council" was appointed by Governor Tim Babcock.

The Image of Public Health

No. 13

William G. Walter, Ph. D.*

An informed public is more likely to be a cooperative and understanding public when matters relating to health are concerned. This has been one of the guiding principles in developing a course "Microbiology in Relation to Man" offered at Montana State University by closed circuit television for the past five quarters. This course has no prerequisites and is a combined lecture - laboratory class which meets daily in two laboratories each accommodating about 40 students. The writer has had the major responsibility for the course, but all microbiologists in the department have shared in the teaching. The lecture emanates from the television studio where students majoring in the Department of Film and Television are mainly responsible for the technical production. The lectures, demonstration, films, and any other special events are video-taped during the first hour's presentation and



then replayed to additional students at subsequent classes. During the past term, approximately 215 students from most of the curricula and from all classes were enrolled. It has been found helpful to have two different students each period present in the studio during the live presentation to serve as "pacers".

Response Acceptable

To date, student response has been quite acceptable. Opinnaires indicate appreciation that all sections receive the same material; that all can see better because each practically has a "front row seat" and can readily observe close-ups of demonstrations or illustrations on the three monitors in each laboratory; and that each can hear better because the lecturer wears a microphone. Some students miss the professor's not being in the

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*Dr. Walter is professor of microbiology at Montana State University. He has served as president of the National Association of Sanitarians and chairman of the Laboratory Section of the American Public Health Association. Currently he is chairman of the Education Committee of the American Society for Microbiology and vice-president of the Montana Association for Mental Health. In 1960 he received the Distinguished Teaching Award at the University.
Dr. Walter graduated from Cornell University and received his doctorate from Michigan State University.

COMPREHENSIVE HEALTH PLANNING WOULD AID STATE

The U. S. Congress has two bills under consideration which would be helpful to Montana. These are entitled "Comprehensive Health Planning and Public Health Services Amendments of 1966".

The two bills are identical, S. 3008 introduced in the Senate and H.R. 13197 in the House of Representatives, John S. Anderson, M.D., executive officer of the SBH says.

This legislation, if enacted, would do away with the many separate categorical health grants to states, substituting a single "block" grant.*

The states would decide through a planning process how the funds would be used. For this purpose a state health planning council would be established, which would represent both governmental and non-governmental agencies concerned with various aspects of public health.

There would also be funds for public health planning on a local or regional basis.

Financial Grants

Financial grants to the states from the Federal government will be determined on the basis of the population and the per capita income of the respective states; except that no such allotment to any state for any fiscal year be less than 1% appropriated. Beginning with the fiscal year ending June 30, 1970, and for each of the next two fiscal years, the Federal share shall not exceed 75% of the cost.

During the period from July 1, 1966, and ending June 30, 1972, there will be granted to any public or nonprofit private agency, institution or other organization, funds to cover all or any part of the cost of projects for training, studies, or demonstrations looking toward the development of improved or more effective comprehensive health planning throughout the nation.

Allocation of Funds to Local Area

The proposed law requires that at least 15% of a State's allotment shall be available to the State Mental Health Authority for the provision under the State plan of mental health services. At least 70% of this amount and at least 70% of the remainder of a State's allotment shall be available only for the provision of services in the communities of the State and used in accordance with the State plan.

These funds for local communities for the fiscal year ending June 30, 1968, and each of the next four fiscal years will be authorized as may be necessary to cover part of the cost of: (1) providing services to meet the health needs of limited geographic scope or of specialized regional or national significance; (2) stimulating and supporting for an initial period new programs of health services or (3) understaking studies, demonstrations, or training designed to develop new methods of improving existing methods of providing health services.

Benefits to Montana

Dr. Anderson says the State would benefit by the allocation of Federal grants under this legislation because it would do away with the existing individual categorical health grants to states, substituting a single "block" grant. For example, Montana could decide to emphasize tuberculosis control rather than heart disease or vice versa. At the present time the grant system is not flexible—that is, the State has no opportunity to use Federal funds to meet what it considers its greatest need but must use the categorical grant for the particular disease program or health problem for which it was specifically appropriated.

Dr. Anderson further states that the single "block" grant would reduce the auditing restrictions which now create ridiculous situations. For instance, if an employee such as a public health nursing consultant is paid from heart disease control funds, another from cancer funds it is too costly in time and money to send both of them to a community to supervise a local nurse who was working in both disease control programs, when one consultant could give the necessary supervision.

Accounting procedures have become more and more rigid so that the States have to prove that a single public health nurse spent ⅛ of her time in cancer, 3/16 on heart, etc. The nurse has to keep time studies of her daily activities. These same restrictions apply to other staff members assigned to categorical programs as well as to public health nurses.

Dr. Anderson feels that the most important part of the bill for Montana is the requirement that 70% of the State's grant is to be applied locally. He feels that this would provide the stimulator we need in Montana for organizing more public health services on a local level. Montana now has only two full time health departments. Half of the counties do not have local sanitarian services and a third do not have public health nursing services. Currently only $23,000 is distributed to local health departments to subsidize public health services.

Objections

The objection Dr. Anderson finds in the proposed bill is that the formula for allotments to states is based on population with an adjustment for per capita income. This is the traditional formula and Montana comes out about "average" in this respect. However, he feels that some consideration should be made for the high cost of "space"—that is, States with small populations distributed over large geographical areas find it more difficult and more costly to provide services than do the smaller more populated states. Therefore this fact should be included in consideration of the formula for the grants. If one looks at a map of the United States showing counties with organized public health departments these are directly proportional to population density with wide areas of the mountain states and upper midwest having few local health departments. It is not that the people living in such areas do not have public health problems. They have a different spectrum of problems to be sure, but problems none-the-less.

Dr. Anderson has informed the proponents of the Bill of this objection and has asked that they give it consideration. He says he feels that this is an important piece of legislation for public health and will do what the State Health Officers have been asking for the past several years.

*The only exception appears to be the Vaccinating Assistance Program.

Coming Events . . . .

Aug. 25—Advistory Committee to the SBH Venereal Disease Control Program, Helena.

Sept. 8 & 9—Montana Association for Rehabilitation, Great Falls.

Oct. 31 - Nov. 4—American Public Health Association, San Francisco.

THE LIVES WE SAVE MAY BE OUR OWN

The guest editorial is reprinted below with the permission of the Editorial Editor of the Great Falls Tribune. It appeared in the June 8, 1966, issue of that publication

One of the most exciting challenges in medicine today is to shorten the gap between the time when a medical discovery is made at a research center and the time when it becomes available to the family physician at the bedside of his grassroots patient. This is a particularly challenging problem in the field of heart disease in which there have been so many dramatic developments in the past decade. It is also a particularly challenging problem in Montana where there is no medical school within the state to serve as a nucleus for the dissemination of post-graduate medical education or for the demonstration of new principles in disease management. Since a medical school within Montana is an impossibility for a good number of years. we must be searching for bold and imaginative new ways to provide continuing education, demonstration and information at one or several points within the state and to disseminate it to every outlying community.

The Heart Diagnostic Center of the Montana State Board of Health for more than 10 years has offered a pilot service to Montana physicians and their patients in the relatively small area of rheumatic and congenital heart disease in which there have been spiralling developments during that interval. Our job has been to keep abreast of progress in the surgical reconstruction of congenital (birth) heart defects and in replacement of heart valves scarred by rheumatic fever, in the thrilling conquest of a disease devastation previously thought to be as incorrectable as an earthquake. Patients suspected of needing these procedures are referred to our Great Falls Center by their family physicians for evaluation. In this program we have demonstrated in one small area of medicine one way a need can be met. We need to experiment with many other ways of disseminating all information of the medical knowledge explosion.

Some national legislation of the past two years may point to possible directions for Montana and other Western states to go. The law outlining the development of Regional Centers for Heart Disease, Cancer and Stroke (P.L. 89-239) may provide ways for information to spread quickly from university centers to subcenters, of which we could have at least three and possibly more in Montana, and thence to small community hospitals and local medical personnel. Other new laws permit grants for improvement of community medical facilities. The potential in all of these laws is great but they depend almost entirely on local and state initiative for their development. Dr. Paul Gans of Lewistown, president of the Montana Medical Association, has appointed a statewide committee of physicians to work to this end. Ultimately, both professional and lay people in every locality will want to work with this and related groups if they wish to insure that the maximal local value is gained from any proposal.

All of us should address ourselves to exploring these new possibilities of learning and teaching which may help to reduce the time gap between medical discovery and application in our own communities. The lives we save may be our own.

BETTY S. GILSON, M.D.
Director, Heart Diagnostic Center, Montana State Board of Health.

Editor's note: Dr. Gilson is director of the Montana Heart Diagnostic Center, an activity of the Montana State Board of Health. The Center is located in the Montana Deaconess Hospital in Great Falls and serves physicians and their patients of the entire state. During the past year, patients from 51 of the 56 counties were seen at the Heart Diagnostic Center.

THE IMAGE OF PUBLIC HEALTH

(Continued from page 1)

classroom so that he can answer questions as they arise. However, not many interrupt a lecturer in a large classroom, so this does not seem too critical. In each lab there is a graduate assistant and usually a senior majoring in microbiology who answers questions, leads discussions, and assists in laboratory experiments performed after a lecture is finished.

Wherein does all of this have a bearing on the images of public health? Mainly in the fact that each year more than 600 students not majoring in bacteriology register in this course, often as an elective in which they get some insight into the scientific method, and hopefully develop some appreciation of cell biology and the role that micro-organisms play in their daily lives. They consider the importance of water purification, sewage treatment, pasteurization of milk, and proper processing of foods. The scientific reasons for fluoridation of water and the importance of a sterile spacecraft on Mars are among other subjects discussed. In addition, the host-parasite relationship and the necessity of various immunization programs are presented in considerable detail. All of these contribute to a broader background and a better understanding of various facets of public health. It is our hope that as these young people assume their role in the community, they will be better informed and hence more understanding and cooperative in the support of public health projects.

Closed circuit television is not the only way that this can be done, but with increased student enrollments and greater demands on faculty, this medium is a partial answer to giving a large segment of the student body some appreciation of public health.

The possibilities for using closed circuit television throughout the state to build a better image of public health have not been explored to any extent. This area must be considered seriously if we expect to extend the horizons of public health in the Big Sky Country rapidly enough to meet the growing demands.

Board Re-elects Officers

The Montana State Board of Health at its July meeting re-elected R. J. Losleben, Malta, President; Robert K. Knapp, M.D., Wolf Point, Vice-President, and John S. Anderson, M. D., M.P.H., Secretary.

George H. Gould, M.D., Kalispell, has been reappointed to the Board by Governor Babcock for a seven-year term ending June 10, 1973. Dr. Gould has been on the Board since June, 1964, when he was appointed to fill the vacancy created by the death of Otto G. Klein, M.D., Helena.

Vern Sloulin, Helena, was reappointed as Secretary of the Sanitarian's Registration Council by the Board at this meeting.

Self-Support Possible For Many Retardates

This is the first article in a series on "Employment of the Retarded".

It is estimated that with adequate training and employment opportunities, about 85% of the retarded could become capable of self-support, at least to some degree.

The all too prevalent myth that job opportunities for retarded individuals are highly limited must be abolished. A high mental age is no more indication of success for many types of jobs than a low mental age is an indication of failure.

The retardate cannot be prepared for a job that requires a high degree of academic skill, but much of the world's work is done by "ordinary" people. Fortunately, much of it does not require a high degree of academic training or high level intellectual functioning. Some of the mildly retarded can hold jobs requiring a considerable amount of responsibility as well as routine activities.

Vocationally, the largest number of employable retarded persons function best at a semi-skilled or unskilled job. although some retarded persons often develop high degrees of skill in a particular area. The young men often do well in mechanical fields. One young man had a job in a steel mill working on a machine which processed pipe. He was friendly, industrious, and interested in his job. After a year on this assignment, he was promoted to foreman and made a success of this endeavor.

Another example is the success of a key operator working in a duplicating equipment office who was the only person in the office who could get the equipment running smoothly again after a mechanical breakdown.

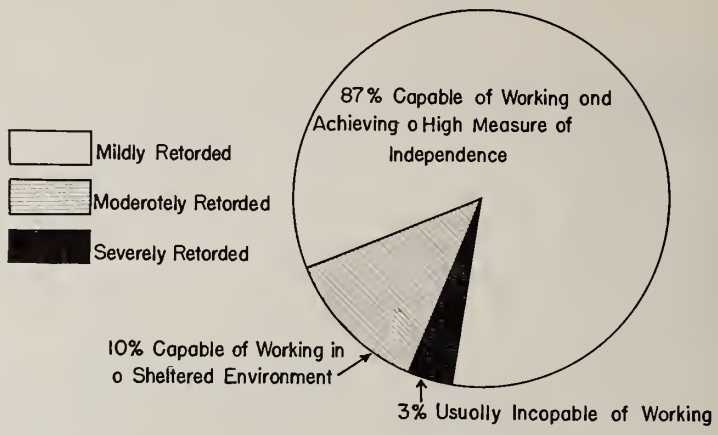
One of the "fortunate difficulties" that develops in finding the retarded in any community is that on reaching adulthood many of the retardates have been absorbed into the working force. They are no longer classified as "retarded" since they are now no longer measured by their academic abilities as they were during their school years.

Qualities Employers Find Among the Retarded

The retarded have proven particularly valuable employees because of their low turnover in jobs which many other workers are willing to hold only temporarily. As a rule, the retarded are highly motivated, are willing to work and eager to please. Many of them have the ability and willingness to follow directions. They are reliable in attendance, prompt, friendly, and have a high tolerance—even preference—for the routine, repetitive tasks which ofen cause dissatisfaction and high turnover among other employees.

CHART I

MOST OF THE MENTALLY RETARDED ARE CAPABLE OF ACQUIRING JOB SKILLS



FROM U.S. DEPT. OF LABOR, MANPOWER RESEARCH, OCT. 1964

Placement Possibilities High

The Department of Labor* estimates that the employment of service workers is expected to increase at a rate considerably above the average for the entire work force in the years ahead. The number of workers in service jobs is expected to increase from 8.3 million in 1960 to 11 million in 1970, and to 12.5 million in 1975. It is in the service occupations where the fastest growing occupational opportunities exist in which the retarded are likely to qualify for training and employment.

Costs of training service workers are relatively low because the courses are short, do not offer difficult curriculum problems, require little in the way of supplies and equipment, and either use existing facilities or require no special facilities.

Since it has been found this large number of retardates can be trained and placed in jobs in which they can perform satisfactorily, and since their training is relatively inexpensive, it seems that what is needed now is a change in the attitude of society. Apparently society has not yet decided to make the kind of social and economic investment which will have a significant impact upon the training needs of a large number of mentally retarded. Greater efforts will also be required of government, industry, and private agencies to prepare these individuals for the world of work and for full participation in the life of the community.

Areas of Success

Retarded persons often are successful in hospitals and other institutions as attendants, orderlies, and nurses aides. Although some of the tasks involved may be considered menial by others, retardates benefit from a heightened sense of personal worth when performing simple tasks that visibly increase the well-being of persons entrusted to their care.

Also by employing the mentally retarded, many hospitals and other institutions providing services for the sick and the aged can make better use of their more highly skilled workers in a number of occupational categories where shortages exist.

(To Be Continued)

*Dept. of Labor Bulletin, Oct. 1964: **"The Mentally Retarded": Their Special Learning Needs.**

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